

6763

CERTIFICATE OF DEATH

06743

Reg. Dist. No.

260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne X/			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) James Upsbur, Anderson				4. DATE OF DEATH Month June Day 24 Year 1957			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1870	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer			10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Anderson				14. MOTHER'S MAIDEN NAME Sarah Lankford			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Address Mr. S.H. Anderson Princess Anne, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Int. Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Int. nephritis Chronic hypertension DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 15 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4500 Grams Arterio Sclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no				
20c. TIME OF INJURY Month, Day, Year Hour a. m. no injury p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1, 1957 , to June 24, 1957 , that I last saw the deceased alive on June 24, 1957 , and that death occurred at 7:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Princess Anne, Md. DATE SIGNED George B. Coulbourn							
ACTUAL SIGNATURE George B. Coulbourn M.D.				PHYSICIAN'S NAME (Type) George B. Coulbourn, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-27-57		22c. NAME OF CEMETERY OR CREMATORY St. Andrew Cemetery		22d. LOCATION (City, town, or county) (State) Princess Anne, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Levin H. Wilson				24a. REC'D BY REGISTRAR JUN 28 1957		24b. REGISTRAR'S SIGNATURE G. J. Johnson	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Place of death: _____

Name of deceased: _____

Age: _____

Sex: _____

Marital status: _____

Occupation: _____

Cause of death: _____

Time of death: _____

Place of burial: _____

Signature of physician: _____

Signature of registrar: _____

Signature of informant: _____

Signature of witness: _____

Signature of undertaker: _____

Signature of funeral home: _____

Signature of cemetery: _____

Signature of church: _____

Signature of other: _____

BUREAU V. 1

JUN 28 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06744

6764

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY Somerset		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		c. LENGTH OF STAY IN 1b 77 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Coulborn E. Barkley						4. DATE OF DEATH Month Day Year June 15 1957									
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 18, 1879		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer				10b. KIND OF BUSINESS OR INDUSTRY farming				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Arrick Barkley						14. MOTHER'S MAIDEN NAME Esther Graham									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ada Barkley Eden, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 hrs										PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 57 , to June , 19 57 , that I last saw the deceased alive on 6-15-57 , 19 57 , and that death occurred at Eden , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Lee L. Lawry M.D. Fruitland Md. PHYSICIAN'S NAME (Type) Lee L. Lawry Fruitland, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6-19-57		22c. NAME OF CEMETERY OR CREMATORY Flowers Hill Cemetery Eden, Md.				22d. LOCATION (City, town, or county) (State)					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Princess Anne, Md. 24a. REC'D BY REGISTRAR JUN 24 1957 24b. REGISTRAR'S SIGNATURE Dr. R. J. Johnson															

CERTIFICATE OF DEATH

DECEASED

DATE

PLACE

CAUSE

AGE

SEX

EDUCATION

RELIGION

NAME OF DECEASED

DATE OF DEATH

SEX

EDUCATION

DATE OF BIRTH

RELIGION

NAME OF DECEASED

DATE OF BIRTH

NAME OF DECEASED

RELIGION

DATE OF DEATH

SEX

REMARKS

BUREAU V. 3

JUN 24 1957

RECEIVED

6765

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital				e. STREET ADDRESS Smith Island			
3. NAME OF DECEASED (Type or print) First JOHN Middle LEWIS Last BRADSHAW				4. DATE OF DEATH Month June Day 21 Year 19 57			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Crab & Oyster		11. BIRTHPLACE (State or foreign country) Tylerton, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Bradshaw				14. MOTHER'S MAIDEN NAME Ellen Evans			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address George Delmas Bradshaw--Tylerton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bladder 181X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1953 to June 1957 , that I last saw the deceased alive on June 21 , 19 57 , and that death occurred at 4:30 A. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. G. Rawley M.D.				DATE SIGNED 6/22/57			
PHYSICIAN'S NAME (Type) Dr. C. G. Rawley				ADDRESS (Street, city or town, state) Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 23, 1957		22c. NAME OF CEMETERY OR CREMATORY Tylerton Cemetery		22d. LOCATION (City, town, or county) (State) Tylerton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bradshaw & Sons--Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 6/22/57		24b. REGISTRAR'S SIGNATURE Barbara S. Adams	

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is faint and mostly illegible.

BUREAU V. 1

JUN 25 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06746
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <u>Southern</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u>					c. LENGTH OF STAY IN 1b <u>5 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> <u>03522</u>					
					d. STREET ADDRESS <u>1310 Rice Ave</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sylvia Marie COOKE</u>					4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 25-1938</u>		9. AGE (In years last birthday) <u>18</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Bert Shotts</u>					14. MOTHER'S MAIDEN NAME <u>Amy Ecker</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>But Shotts</u>					17. INFORMANT <u>But Shotts</u> Address <u>1303 Rice Ave</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia: Micrococcus (Staphylococcus) varians</u> <u>Not clearly determined</u> DUE TO (b) <u>at the date - probably Botulism</u> DUE TO (c) <u>Probably due to food poisoning</u> <u>Fatal report to be used for the body report -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>R.H. Johnson</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>June 5-1957</u>
EXAMINER'S NAME (Type) <u>R.H. Johnson</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET CEM.</u>			22d. LOCATION (City, town, or county) (State) <u>HANOVER, PENN.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Father Funeral Home - Catonsville, Md.</u>					24a. REC'D BY REGISTRAR <u>6-5-57</u>		24b. REGISTRAR'S SIGNATURE <u>R.H. Johnson</u>			

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text, likely bleed-through from the reverse side of the document.]

BUREAU V. S.

JUN 12 1957

RECEIVED

6760

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b 39 Crisfield			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Franklin Lane				d. STREET ADDRESS Franklin Lane			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE ELIZABETH GERDNER				4. DATE OF DEATH June 20, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 17, 1906	
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		11. BIRTHPLACE (State or foreign country) Marumsco, Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Garment Mfg.		11. BIRTHPLACE (State or foreign country) Marumsco, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Price				14. MOTHER'S MAIDEN NAME Maggie Ennis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO.			
17. INFORMANT Arthur Gardner, Crisfield, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Acute dilatation of heart Sudden DUE TO (b) Mitral Stenosis, yrs. DUE TO (c) Rheumatic heart disease yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 124.3							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Nov. 1946 to June 1957 that I last saw the deceased alive on June 18, 1957, and that death occurred at 1400 M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Crisfield, Md.				DATE SIGNED 6/22/57			
ACTUAL SIGNATURE C. G. Rawley M. D.							
PHYSICIAN'S NAME (Type) C. G. Rawley, M. D.				Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/23/57		22c. NAME OF CEMETERY OR CREMATORY Rehobeth Baptist Cem.		22d. LOCATION (City, town, or county) (State) Rehobeth, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.				24a. REC'D BY REGISTRAR DATE 6/22/57			
				24b. REGISTRAR'S SIGNATURE Barbara S. Adams			

CERTIFICATE OF DEATH

BUREAU V. S.

JUN 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, address, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G217, 7/8/57 for

6767

CERTIFICATE OF DEATH

Reg. Dist. No.

06748

265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN b. Life time			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCreedy Memorial Hospital				e. STREET ADDRESS 302 Maryland Avenue			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Ida Middle M. Last Handy		4. DATE OF DEATH Month June Day 27 Year 1957					
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30,	9. AGE (In years last birthday) 74 yrs	IF UNDER 1 YEAR Months Days Hours Min 	IF UNDER 24 HRS Months Days Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private home		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Jones				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-05-5030		17. INFORMANT Otto Handy, 302 Maryland Ave., Crisfield, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute dilatation Heart 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic DUE TO (c) heart disease						INTERVAL BETWEEN ONSET AND DEATH 2 w. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 47 , 19 57 , to June , 19 57 , that I last saw the deceased alive on June 27 , 19 57 , and that death occurred at 5:4 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE C. G. Rawley M.D.				ADDRESS (Street, city or town, state) Crisfield, Md. DATE SIGNED 6/29/57			
PHYSICIAN'S NAME (Type) Dr. C. G. Rawley				Main St.--Crisfield, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30, 1957		22c. NAME OF CEMETERY OR CREMATORY Lawsonia Cemetery		22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Harvey Bradshaw				ADDRESS Crisfield, Md.		24a. REC'D BY REGISTRAR DATE 6/29/57	
				24b. REGISTRAR'S SIGNATURE Barton S. Adams			

BUREAU V. S.

JUL 2 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. AT5ME(5)
SM 9/55

6768

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 260

06749

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE So. Carolina b. COUNTY Bamberg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westover		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Govan			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ronnie Middle Lee Last Hudson				4. DATE OF DEATH Month 6 Day 12 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27, 1957	
9. AGE (In years last birthday) yrs. 1 Moths 16 Days 16		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
13. FATHER'S NAME Horace Hudson				14. MOTHER'S MAIDEN NAME Mary Kearse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Horace Hudson		Address Westover, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Diarrhea - child was ill DUE TO Arduous in South Carolina - was seen by a doctor 6-11-57 - came out a maligned - child died before DUE TO (c) Working labor camp at Westover CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. H. Johnson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) R. H. Johnson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6/12/57		22c. NAME OF CEMETERY OR CREMATORY John Wesley		22d. LOCATION (City, town, or county) (State) Princess Anne Md	
23. FUNERAL DIRECTOR'S SIGNATURE William H. James				24a. REC'D BY REGISTRAR 6/13/57		24b. REGISTRAR'S SIGNATURE R. S. Phelan, M.D.	

BUREAU V. 31

UN 14 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6769

CERTIFICATE OF DEATH

Reg. Dist. No.

06750
260

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manokin	
d. NAME OF HOSPITAL (If not in hospital, give street address) Manokin		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katie First Maddox Last		4. DATE OF DEATH Month June Day 21 Year 1957	
5. SEX Fe	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1889 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Manokin	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Ward		14. MOTHER'S MAIDEN NAME Harriett Horsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Bolz Address 827 St. Caroline St. Belting, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 Year 2 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 20, 1957 to June 21, 1957 , that I last saw the deceased alive on June 20, 1957 , and that death occurred at 5:20 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Eldon G. Markham		ADDRESS (Street, city or town, state) Princess Anne road	
PRINTED NAME (Type) Eldon G. Markham			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/24/1957	22c. NAME OF CEMETERY Samuel Wesley	22d. LOCATION (City, town, or county) (State) Manokin, Som. Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Ward		24. REC'D BY REGISTRAR DATE 6/26/57	
ADDRESS Marion Sta., Md.		24b. REGISTRAR'S SIGNATURE R. J. Johnson, M.D. (gt)	

BUREAU V. 3

JUN 27 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6761

CERTIFICATE OF DEATH

06751

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Lawsonia				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle FRANKLIN Last MISTER				4. DATE OF DEATH Month June Day 22 , Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Mister				14. MOTHER'S MAIDEN NAME Anna Byrd			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 218-03-4357		17. INFORMANT Address Mrs. Carl Blueford, Crisfield, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis U.S.U.D. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 5 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State) 				
21. I certify that I attended the deceased from April 26, 1957 , to June 22, 1957 , that I last saw the deceased alive on April 28, 1957 , and that death occurred at 12 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 334 W. Main - Crisfield, Md DATE SIGNED June 24							
ACTUAL SIGNATURE Sarah M. Peyton M.D.		PHYSICIAN'S NAME (Type) Sarah M. Peyton, M. D. Crisfield, Maryland					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/57	22c. NAME OF CEMETERY OR CREMATORY Crisfield Cemetery	22d. LOCATION (City, town, or county) (State) Crisfield, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Maryland ADDRESS 			24a. REC'D BY REGISTRAR 6/28/57	24b. REGISTRAR'S SIGNATURE Betha S. Adams			

BUREAU V. E.

JUL 2 1957

RECEIVED
BUREAU

JUL

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 06752									
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist Columbia b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield			c. LENGTH OF STAY IN 1b few days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Waterfront					d. STREET ADDRESS 652 Eye St., S. W.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMOS Middle RAYMOND Last RICKMAN					4. DATE OF DEATH Month June 9, 1957 Day 19 Year 19				
5 SEX Male		6 COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25, 1901		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Unknown Stuart, Va			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert Rickman					14. MOTHER'S MAIDEN NAME Virginia Rorer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Wallace Rickman, Springfield, Virginia					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Accidental Drowning</u> 350X DUE TO (b) <u>Fill in water</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) His boat was tied to wharf in Hoptown section Crisfield, Md.							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Hoptown wharf		20f. (City or town) Crisfield		(County) Som (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
SIGNATURE W. H. Coulbourn M.D.					DATE SIGNED 6/14/57				
EXAMINER'S NAME (Type) William H. Coulbourn, M. D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Crisfield, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CREMATORY Columbia Gardens			22d. LOCATION (City, town, or county) (State) Arlington, Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons, Crisfield, Md.					24a. REC'D BY REGISTRAR DATE JUN 17 1957		24b. REGISTRAR'S SIGNATURE Barbara Adams		

MEDICAL CERTIFICATION

BUREAU V. 31

N 17 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please note the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06753

Reg. Dist. No.

260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If Institution: Residence before admission) a. STATE <u>Colorado</u> b. COUNTY <u>---</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beemonte R.F.D.</u>		c. LENGTH OF STAY IN 1b <u>0</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Highway 13 - Somerset Co.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meeker Rural</u>	
f. STREET ADDRESS <u>Wilson Creek Route</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Warren T. Roberts</u>		4. DATE OF DEATH <u>June 7 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19 - 1937</u>
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not known</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Colorado</u>	
11. BIRTH PLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. A. Roberts</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Robert</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u>		16. SOCIAL SECURITY NO. <u>at present time</u>	
17. INFORMANT <u>U. S. N. Zepal</u>		Address <u>San Chivichikoyula</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 815X DUE TO (b) <u>Compound fracture left femur</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>Fracture both femurs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Motor accident on Highway 13</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Riding Motorcycle - Hit on Creek with car.</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 6 - 7 1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 13</u>	20f. (City or town) <u>Beemonte R.F.D. Somerset Co. MD</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>June 8 1957</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVY</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. May</u>		24a. RECEIVED BY REGISTRAR <u>June 8 1957</u> 24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson</u>	

RECEIVED

JUN 19 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06754

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>SOLEBURY</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOLEBURY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VINTON</u>		c. LENGTH OF STAY IN 1b <u>4 BYLLES</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VINTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>1</u>		
3. NAME OF DECEASED (Type or print) First <u>DALLAS</u> Middle <u>ROYSTER</u> Last <u>ROYSTER</u>			4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1957</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/1913</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>C.A. SWANSON AND CO. PHILA. PA.</u>		11. BIRTHPLACE (State or foreign country) <u>U S A</u>
13. FATHER'S NAME <u>WILLIAM ROYSTER</u>			14. MOTHER'S MAIDEN NAME <u>DAISY JONES</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>218-65-98513</u>		17. INFORMANT <u>BERNICE ROYSTER, VINTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Coronary Heart Disease</u> <u>1201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Seconds</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u> </u>	(County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>June 10, 1957</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRACE</u>		22d. LOCATION (City, town, or county) <u>VINTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR. PRINCESS ANNE MD</u>		24a. REC'D BY REGISTRAR <u>6-10-57</u>		24b. REGISTRAR'S SIGNATURE <u>R. H. Johnson M.D.</u>	

RECEIVED
JUN 12 1957
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06755
Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <u>Somerset</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pennock R.F.D.</u> c. LENGTH OF STAY IN 1b <u>0</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Lynchburg 13 - Somerset Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Seahoyville - Rural</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seahoyville - Rural</u> d. STREET ADDRESS <u>R.D. #1 69X-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Norman F. Russell</u> First Middle Last 4. DATE OF DEATH <u>June 7 1957</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 7-1934</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>18</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jordan Willard Russell</u> 14. MOTHER'S MAIDEN NAME <u>Phyllis Elizabeth Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S.A. at present time</u> 16. SOCIAL SECURITY NO. <u>U.S.A. Legal Res. Chubbiquette Md.</u> 17. INFORMANT <u>U.S.A. Legal Res. Chubbiquette Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broken Neck. Fracture of</u> <u>815X</u> DUE TO <u>bp by. Fracture right leg</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>bp by. Fracture right leg</u> DUE TO (c) <u>bp by. Fracture right leg</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Motorcycle - Car Accident Highway 13</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Head on collision. Accident -</u>	
20c. TIME OF INJURY Month, Day, Year <u>June 7 1957</u> Hour <u>10:30</u> p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 13 - Pennock R.F.D. Somerset Co.</u> (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <u>R.H. Johnson</u> EXAMINER'S NAME (Type) <u>R.H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>June 8-1957</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>U.S. NAVY</u> 22b. DATE THEREOF <u>June 8-1957</u> 22c. NAME OF CEMETERY OR CREMATORY <u>U.S. NAVY</u> 22d. LOCATION (City, town, or county) (State)		23. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. May</u> ADDRESS <u>U.S. NAVY</u> 24a. REC'D BY REGISTRAR <u>6-8-57</u> DATE <u>6-8-57</u> 24b. REGISTRAR'S SIGNATURE <u>R.H. Johnson</u>	

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RECEIVED
JUN 12 1957
BUREAU V. S.

RECEIVED
JUN 12 1957
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-58 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06756

6773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>SOMERSET</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>SOMERSET</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DEAL ISLAND</u>		<u>LIFE</u>		TOWN <u>DEAL ISLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>AT HOME</u>				<u>1 MAIN RD</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>SAMUEL JAMES WATERS</u>				<u>JUNE 2 1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>NEGRO</u>	<u>MARRIED</u>	<u>AY 6-1882</u>	<u>74</u> yrs.	Months <u>+</u>	Days <u>+</u>	Hours <u>+</u> Min. <u>+</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Retired</u>		<u>DEAL ISLAND MD</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>HENRY WATERS</u>				<u>CHARLOTTE HAMSTRONG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>211-16-9041</u>		<u>ADDIE WATERS - wife</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
177X IMMEDIATE CAUSE (A) <u>Marked Cachexia</u>						<u>2 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adenocarcinoma of prostate</u>						<u>26 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-21-57</u> , 19 <u>57</u> , to <u>6-2-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-2-57</u> , 19 <u>57</u> , and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>E. Sutton</u>		DATE HEREOF <u>6/5/57</u>		ADDRESS (Street, city, town, state) <u>Danes Quarter, Maryland</u>		DATE SIGNED <u>6-4-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Buried</u>		<u>John Wesley Cemetery</u>		<u>Deal Island Md</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>6/10/57</u>		<u>Lola Wheatley</u>		<u>L. S. Liberator</u>		<u>Deal Island Md</u>	

CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF CREMATION

PLACE OF CREMATION

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF EXHUMATION

PLACE OF EXHUMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

1. NAME

2. SEX

3. AGE

4. RACE

5. EDUCATION

6. OCCUPATION

7. RELIGION

8. DATE OF BIRTH

9. PLACE OF BIRTH

10. DATE OF ENTRY

11. PLACE OF ENTRY

12. DATE OF DEPARTURE

13. PLACE OF DEPARTURE

14. DATE OF RETURN

15. PLACE OF RETURN

16. DATE OF DEATH

17. PLACE OF DEATH

18. DATE OF BURIAL

19. PLACE OF BURIAL

20. DATE OF CREMATION

21. PLACE OF CREMATION

22. DATE OF INTERMENT

23. PLACE OF INTERMENT

24. DATE OF EXHUMATION

25. PLACE OF EXHUMATION

26. DATE OF REINTERMENT

27. PLACE OF REINTERMENT

28. DATE OF DEATH

29. PLACE OF DEATH

30. DATE OF BURIAL

31. PLACE OF BURIAL

32. DATE OF CREMATION

33. PLACE OF CREMATION

34. DATE OF INTERMENT

35. PLACE OF INTERMENT

36. DATE OF EXHUMATION

37. PLACE OF EXHUMATION

38. DATE OF REINTERMENT

39. PLACE OF REINTERMENT

40. DATE OF DEATH

41. PLACE OF DEATH

42. DATE OF BURIAL

43. PLACE OF BURIAL

44. DATE OF CREMATION

45. PLACE OF CREMATION

46. DATE OF INTERMENT

47. PLACE OF INTERMENT

48. DATE OF EXHUMATION

49. PLACE OF EXHUMATION

50. DATE OF REINTERMENT

51. PLACE OF REINTERMENT

52. DATE OF DEATH

53. PLACE OF DEATH

54. DATE OF BURIAL

55. PLACE OF BURIAL

56. DATE OF CREMATION

57. PLACE OF CREMATION

58. DATE OF INTERMENT

59. PLACE OF INTERMENT

60. DATE OF EXHUMATION

61. PLACE OF EXHUMATION

62. DATE OF REINTERMENT

63. PLACE OF REINTERMENT

64. DATE OF DEATH

65. PLACE OF DEATH

66. DATE OF BURIAL

67. PLACE OF BURIAL

68. DATE OF CREMATION

69. PLACE OF CREMATION

70. DATE OF INTERMENT

71. PLACE OF INTERMENT

72. DATE OF EXHUMATION

73. PLACE OF EXHUMATION

74. DATE OF REINTERMENT

75. PLACE OF REINTERMENT

76. DATE OF DEATH

77. PLACE OF DEATH

78. DATE OF BURIAL

79. PLACE OF BURIAL

80. DATE OF CREMATION

81. PLACE OF CREMATION

82. DATE OF INTERMENT

83. PLACE OF INTERMENT

84. DATE OF EXHUMATION

85. PLACE OF EXHUMATION

86. DATE OF REINTERMENT

87. PLACE OF REINTERMENT

88. DATE OF DEATH

89. PLACE OF DEATH

90. DATE OF BURIAL

91. PLACE OF BURIAL

92. DATE OF CREMATION

93. PLACE OF CREMATION

94. DATE OF INTERMENT

95. PLACE OF INTERMENT

96. DATE OF EXHUMATION

97. PLACE OF EXHUMATION

98. DATE OF REINTERMENT

99. PLACE OF REINTERMENT

100. DATE OF DEATH

101. PLACE OF DEATH

102. DATE OF BURIAL

103. PLACE OF BURIAL

104. DATE OF CREMATION

105. PLACE OF CREMATION

106. DATE OF INTERMENT

107. PLACE OF INTERMENT

108. DATE OF EXHUMATION

109. PLACE OF EXHUMATION

110. DATE OF REINTERMENT

111. PLACE OF REINTERMENT

112. DATE OF DEATH

113. PLACE OF DEATH

114. DATE OF BURIAL

115. PLACE OF BURIAL

116. DATE OF CREMATION

117. PLACE OF CREMATION

118. DATE OF INTERMENT

119. PLACE OF INTERMENT

120. DATE OF EXHUMATION

121. PLACE OF EXHUMATION

122. DATE OF REINTERMENT

123. PLACE OF REINTERMENT

124. DATE OF DEATH

125. PLACE OF DEATH

126. DATE OF BURIAL

127. PLACE OF BURIAL

128. DATE OF CREMATION

129. PLACE OF CREMATION

130. DATE OF INTERMENT

131. PLACE OF INTERMENT

132. DATE OF EXHUMATION

133. PLACE OF EXHUMATION

134. DATE OF REINTERMENT

135. PLACE OF REINTERMENT

136. DATE OF DEATH

137. PLACE OF DEATH

138. DATE OF BURIAL

139. PLACE OF BURIAL

140. DATE OF CREMATION

141. PLACE OF CREMATION

142. DATE OF INTERMENT

143. PLACE OF INTERMENT

144. DATE OF EXHUMATION

145. PLACE OF EXHUMATION

146. DATE OF REINTERMENT

147. PLACE OF REINTERMENT

148. DATE OF DEATH

149. PLACE OF DEATH

150. DATE OF BURIAL

151. PLACE OF BURIAL

152. DATE OF CREMATION

153. PLACE OF CREMATION

154. DATE OF INTERMENT

155. PLACE OF INTERMENT

156. DATE OF EXHUMATION

157. PLACE OF EXHUMATION

158. DATE OF REINTERMENT

159. PLACE OF REINTERMENT

160. DATE OF DEATH

161. PLACE OF DEATH

162. DATE OF BURIAL

163. PLACE OF BURIAL

164. DATE OF CREMATION

165. PLACE OF CREMATION

166. DATE OF INTERMENT

167. PLACE OF INTERMENT

168. DATE OF EXHUMATION

169. PLACE OF EXHUMATION

170. DATE OF REINTERMENT

171. PLACE OF REINTERMENT

172. DATE OF DEATH

173. PLACE OF DEATH

174. DATE OF BURIAL

175. PLACE OF BURIAL

176. DATE OF CREMATION

177. PLACE OF CREMATION

178. DATE OF INTERMENT

179. PLACE OF INTERMENT

180. DATE OF EXHUMATION

181. PLACE OF EXHUMATION

182. DATE OF REINTERMENT

183. PLACE OF REINTERMENT

184. DATE OF DEATH

185. PLACE OF DEATH

186. DATE OF BURIAL

187. PLACE OF BURIAL

188. DATE OF CREMATION

189. PLACE OF CREMATION

190. DATE OF INTERMENT

191. PLACE OF INTERMENT

192. DATE OF EXHUMATION

193. PLACE OF EXHUMATION

194. DATE OF REINTERMENT

195. PLACE OF REINTERMENT

196. DATE OF DEATH

197. PLACE OF DEATH

198. DATE OF BURIAL

199. PLACE OF BURIAL

200. DATE OF CREMATION

201. PLACE OF CREMATION

202. DATE OF INTERMENT

203. PLACE OF INTERMENT

204. DATE OF EXHUMATION

205. PLACE OF EXHUMATION

206. DATE OF REINTERMENT

207. PLACE OF REINTERMENT

208. DATE OF DEATH

209. PLACE OF DEATH

210. DATE OF BURIAL

211. PLACE OF BURIAL

212. DATE OF CREMATION

213. PLACE OF CREMATION

214. DATE OF INTERMENT

215. PLACE OF INTERMENT

216. DATE OF EXHUMATION

217. PLACE OF EXHUMATION

218. DATE OF REINTERMENT

219. PLACE OF REINTERMENT

220. DATE OF DEATH

221. PLACE OF DEATH

222. DATE OF BURIAL

223. PLACE OF BURIAL

224. DATE OF CREMATION

225. PLACE OF CREMATION

226. DATE OF INTERMENT

227. PLACE OF INTERMENT

228. DATE OF EXHUMATION

229. PLACE OF EXHUMATION

230. DATE OF REINTERMENT

231. PLACE OF REINTERMENT

232. DATE OF DEATH

233. PLACE OF DEATH

234. DATE OF BURIAL

235. PLACE OF BURIAL

236. DATE OF CREMATION

237. PLACE OF CREMATION

238. DATE OF INTERMENT

239. PLACE OF INTERMENT

240. DATE OF EXHUMATION

241. PLACE OF EXHUMATION

242. DATE OF REINTERMENT

243. PLACE OF REINTERMENT

244. DATE OF DEATH

245. PLACE OF DEATH

246. DATE OF BURIAL

247. PLACE OF BURIAL

248. DATE OF CREMATION

249. PLACE OF CREMATION

250. DATE OF INTERMENT

251. PLACE OF INTERMENT

252. DATE OF EXHUMATION

253. PLACE OF EXHUMATION

254. DATE OF REINTERMENT

255. PLACE OF REINTERMENT

256. DATE OF DEATH

257. PLACE OF DEATH

258. DATE OF BURIAL

259. PLACE OF BURIAL

260. DATE OF CREMATION

261. PLACE OF CREMATION

262. DATE OF INTERMENT

263. PLACE OF INTERMENT

264. DATE OF EXHUMATION

265. PLACE OF EXHUMATION

266. DATE OF REINTERMENT

267. PLACE OF REINTERMENT

268. DATE OF DEATH